U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 05 May 2004

CASE NO.: 2003-LHC-1586

OWCP NO.: 07-156285

IN THE MATTER OF:

KENNETH BORDELON,
Claimant,

v.

PATTERSON SERVICE, INC.,
Employer

and

RELIANCE INSURANCE,
Carrier

APPEARANCES:

Aubrey Denton, Esq.,
On behalf of Claimant

Dona Renegar, Esq.,
On behalf of Employer

BEFORE: Clement J. Kennington
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, et seq., (2003) brought by Kenneth

Bordelon (Claimant) against Patterson Services, Inc., (Employer) and Reliance Insurance (Carrier). The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for a formal hearing. A hearing was held before the undersigned on November 20, 2003, in Lafayette, Louisiana.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their positions. Claimant testified and introduced six photographs of the worksite which were admitted into evidence.[1] Employer and Claimant introduced twenty-two (22) joint exhibits, which were admitted, including: depositions and medical records of Drs. Vierra, Hebert, Gidman, Louis and Sonnier; medical records of Drs. Montgomery, Smith, Budden and Mounir; Medical records of Our Lady of Lourdes Hospital, McLeod Trahan Physical Therapy, Lafayette General Medical Center, Laborde Diagnostics; and compensation payment information.

Post-hearing briefs were filed by the parties.[2] Based upon the stipulations of the parties, the evidence introduced, my observation of the witness demeanor and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. Claimant was injured on February 7, 1998;

2. The injury was in the course and scope of employment;

3. An employer/employee relationship existed at the time of the injury;

4. Employer was advised of the injury on February 7, 1998;

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[1] References to the transcript and exhibits are as follows: trial transcript- Tr.__; Claimant's exhibits- CX- , p.__; Employer exhibits- EX-__, p.__; Administrative Law Judge exhibits- ALJX-__; p.___.

[2] Claimant submitted a 20-page post-hearing brief on March 4, 2004. Employer submitted a 16-page post-hearing brief on March 4, 2004.

5. Notices of Controversion were filed on November 12, 2001; June 18, 2002; and January 29, 2003;

6. An informal conference was held on January 8, 2003;

7. Claimant's average weekly wage at the time of the injury was $1,173.17;

8. Employer paid Claimant temporary total disability benefits from March 1, 2000 to July 26, 2000 for a total of 21 weeks and $16,537.10. Employer paid Claimant temporary partial disability benefits from March 7, 2001, to June 27, 2001, for a total of 16.1 weeks and $12,626.30. The total amount of compensation benefits paid is $29,163.40.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Causation and the Section 20(a) presumption;

2. Nature and extent of Claimant's disability;

3. Attorney's fees.

III. STATEMENT OF THE CASE

A. Chronology:

Claimant is a 53-year old diabetic male who worked offshore for Employer. On February 7, 1998, he suffered a crush injury to his left foot when a large piece of iron fell from a hammer and struck his foot. Claimant treated with Dr. Sonnier, a family practitioner, who diagnosed him with a contusion and swelling of the left foot; he discharged Claimant on February 17, 1998, as he was asymptomatic at that time. However, Claimant returned in March, 1998, with complaints of increased pain and swelling in his left foot. A bone scan performed March 12 indicated several healing factures of Claimant's left metatarsal bones. Dr. Sonnier then referred Claimant to Dr. Gidman, an orthopedic surgeon, who first treated Claimant April 1, 1998. Dr. Gidman noted a mild displacement of Claimant's left

metatarsal bones and decreased sensation in Claimant's left foot. X-rays taken in September, 1998, revealed significant degenerative changes in the areas of Claimant's metatarsal fractures.

Claimant experienced continued swelling and pain in his left foot through the spring of 1999. Dr. Gidman noted Claimant discontinued his diabetes medication in May, 1999, and his blood sugar levels were critically high in June, 1999. On July 21, 1999, Dr. Gidman found an ulcer on Claimant's left great toe; Claimant also informed him he resumed taking Glucotrol for his diabetes. Dr. Gidman referred Claimant to Dr. Hebert, an orthopedic surgeon who specialized in foot conditions and surgeries. On August 4, 1999, Claimant presented to Dr. Hebert with neuropathy of his left foot and an ulcer on his left great toe. In March, 2000, Dr. Hebert performed surgery on the ulcer, which healed without infection as of July, 2000. In November, 2000, Claimant developed an ulcer on his right foot, and by February, 2001, his left foot ulcer reappeared. Dr. Hebert noted Claimant's left ulcer healed by June, 2001, but in September, 2001, he diagnosed Claimant with bilateral great toe ulcers. Claimant suffered bilateral toe ulcers throughout 2002, and in January, 2003, Dr. Hebert amputated his left third toe, which had become gangrenous; he removed Claimant from heavy manual work. In April, 2003, Claimant returned to Dr. Hebert with continued ulcerations on his left foot. In December, 2003, Dr. Hebert operated on Claimant's left foot to correct the claw-like deformity of his toes and prevent the chronic ulcerations.

B. Claimant's Testimony

Claimant is a 53-year old high school graduate who resides in Duscon, Louisiana. (Tr. 17). He first worked for Employer from 1978-1985 as a hammer driver offshore. Claimant was laid off in 1985, but returned to Employer in 1998 in the same capacity. (Tr. 17-19, 26). Claimant primarily drove conductor pipe, measuring 30 inches in diameter and 40 feet in length, into the ground as a protective casing for the oil well. (Tr. 20, 18). The hammer he used was diesel powered and weighed approximately 32,000 pounds; pipe slings attached to the hammer were used to pick up the pipes and padeyes helped lift the pipe to fit it underneath the hammer. (Tr. 21-23, 25).

On February 7, 1998, Claimant was working a job on South March Island, Block 23, approximately 15-20 miles offshore on the Outer Continental Shelf. He and his crew were on the third or fourth joint when the hammer and equipment, including slings, pipes and padeyes, fell from the top of the rig. A padeye hit

Claimant on his left foot, crushing the steel toe in his boot. (Tr. 27-29). Claimant testified LifeFlight flew out to the rig to take a welder into the hospital; the next morning Claimant's foot was so swollen Employer flew him into Lafayette General Hospital. Claimant was told his foot was fractured in multiple locations; Employer placed him on light duty in the yard while he was recovering. (Tr. 31-32).

Following his trip to the emergency room, Claimant treated with the company doctor, Dr. Sonnier, and then Dr. Gidman, an orthopedic surgeon. Dr. Gidman referred Claimant to Dr. Hebert because he had developed an ulcer on his left big toe; Claimant did not remember Dr. Hebert telling him his diabetes could aggravate the ulcer. Claimant testified he did not have problems with his left foot immediately after the accident. (Tr. 33-34, 59). Dr. Hebert performed surgery on Claimant's left foot in March, 2000, to remove the bone spur on the bottom of his big toe; it healed within a few months. In June, 2000, Claimant presented to Dr. Montgomery with an ulcer on his right foot, which was not injured in the 1998 accident. (Tr. 35, 63-64). Claimant returned to work, but his toe continued to bother him. He remained off work from March, 2001, through June, 2001, because he did not want surgery, but thought rest would help his foot heal. (Tr. 36-37). Although Claimant tried to take off work in 2002 secondary to problems with his foot, he was denied workers compensation and ultimately could not afford to take time off. (Tr. 55).

Claimant testified he arrived at the offshore rigs by work boats; in rough weather it was necessary to have a good foot hold when loading onto the rig. A hammer job would last about 20-35 hours, during which time Claimant was constantly on his feet. He currently does not have feeling in the bottom of his feet. (Tr. 40-41). After returning to work in June, 2001, Claimant worked through January 27, 2003, when he was forced to quit after one of the toes on his left foot was amputated secondary to gangrene. Claimant's diabetes doctor, Dr. Louis, performed the surgery. (Tr. 41-43). Claimant testified he had a pre-existing injury to his right big toe, but it healed without an infection and he did not have problems with blisters. (Tr. 44-45, 50). He never had problems with his left big toe before the 1998 accident; specifically he did not suffer from numbness in his left foot. When his symptoms began after the accident, however, Claimant lost feeling in his left foot and when he was fitted for work boots his big and second toes swelled up causing him pain. (TR. 46-47). When Claimant walked for a while he suffered bolts of pain shooting from his foot into his leg. Additionally, he has had blisters and infections on his left foot following his 1998 crush injury. (Tr. 46-48). In January, 2003, Claimant was placed on no-work status by his doctors, Dr. Louis, Dr. Hebert and Dr. Holden. Since then, he stayed off his feet, continued treatment

with his doctors and took antibiotics. Claimant wore a special shoe to keep pressure off of his toes; however, he still experienced drainage problems with his left foot. (Tr. 50-51).

Claimant testified he had childhood diabetes, and that he had problems with it again in 1978. He was required to take three shots a day to control his diabetes, although that did not affect his ability to work offshore. (Tr. 48-49). He testified he did not take diabetes medication at the time of the 1998 accident, although on cross-examination he deferred to his medical records for the precise day he started his medications. (Tr. 56-57). Claimant stated he did not remember treating for diabetes with Dr. Sonnier, or that Dr. Sonnier tried to prescribe him diabetes medication in 1999. (Tr. 61). In July, 2000, Claimant presented to Dr. Louis with heart problems; a few days later he went to the hospital where he was injected with insulin for his diabetes. (Tr. 65-66). Claimant testified his father died of diabetes and a heart attack. (Tr. 69).

On cross-examination, Claimant testified he suffered ulcers on his left foot in February, 2001, after which Dr. Hebert recommended custom orthotics and shoes. He returned to Employer in June, 2001, but continued to have problems with ulcers on his right foot, which he treated himself while working. (Tr. 67). Following his accident, Claimant informed Dr. Sonnier he drank 4-5 beers daily. He did not recall Dr. Hebert advising him to avoid alcohol; he was still drinking 2-3 beers a night in January, 2003. (Tr. 57, 68-69). Claimant did not have problems with his left foot again until January, 2003, when he developed an ulcer on his middle toe; he did not remember developing an infection in the third toe which he treated himself. (Tr. 68-69).

C. Exhibits

(1) Depositions and Medical Records of Patrick A. Sonnier, M.D., Gregory Gidman, M.D. and Our Lady of Lourdes Medical Center

Claimant was admitted to Our Lady of Lourdes Medical Center on February 8, 1998, following his work accident. He presented to the emergency room with a purple, swollen left foot. Claimant also experienced decreased sensation of the left foot. X-rays showed metatarsal fractures of the left foot. (JX-9, p. 190).

Claimant saw Dr. Sonnier on February 9, 1998.[3] At this first visit, Claimant had minimal complaints of left foot pain; x-rays from February 8, 1998, showed no fractures in his left foot. However, Claimant's left foot was bruised and Dr. Sonnier diagnosed him with a contusion. Claimant informed him he was on diabetic medication and drank 4-5 beers nightly. (JX-17, pp. 6-11). Dr. Sonnier released Claimant to light duty; on February 13 his complaints were not pronounced and on February 17 Dr. Sonnier discharged Claimant as he was asymptomatic. *Id.* at 12-13.

Claimant returned to Dr. Sonnier on March 9, 1998, with complaints of left foot pain and swelling. He informed the doctor his foot had remained swollen since the accident one month earlier. Claimant also complained of point tenderness over the dorsum of the left foot and numbness of the left foot. Dr. Sonnier ordered a bone scan, performed March 12, 1998, which revealed multiple healing fractures of the left metatarsal bones. He referred Claimant to Dr. Gidman, an orthopedic surgeon for further treatment. (JX-17, pp. 13-16, 30). Dr. Sonnier testified Claimant's foot injuries were related to his work accident. However, he stated metatarsal fractures generally do not cause ulcers; he has not seen that in his 35 years of practice. Dr. Sonnier testified Claimant's ulcers were probably caused by his diabetes more than his metatarsal fractures. He then clarified he never examined, treated or even knew of any ulcers on Claimant's feet; he deferred to Dr. Gidman and Dr. Hebert for opinions as to Claimant's particular condition. *Id.* at 25, 28-29, 33-35.

Dr. Gidman testified by deposition on November 18, 2003; the parties accepted him as an expert witness in the field of orthopedic surgery. Dr. Gidman first examined Claimant on April 1, 1998, on a referral from Dr. Sonnier.[4] (JX-3, pp. 5-6). Claimant presented with left foot pain and swelling. Dr. Gidman noted at least four bone fractures in Claimant's left foot; he testified such fractures normally heal within 6 weeks, although the accompanying symptoms may continue up to one year. Dr. Gidman also noted Claimant's second metatarsal healed with a mild displacement, which was a permanent deformity. Dr. Gidman testified Claimant had decreased sensation in his left foot. He stated decreased sensation could lead to the inability to feel ulcers or infections, thus such conditions could go untreated. Claimant had no ulcers on his left foot at this first visit, although there was an ulcer

[3] Dr. Sonnier testified by deposition on December 2, 2003, and was accepted by the parties as an expert witness in the field of family medicine. (JX-17, pp. 5-6).

[4] Dr. Gidman treated Claimant on nine occasions over a one-year period. He examined Claimant on April 1 and 20, 1998; June 17, 1998; September 17, 1998; February 22, 1999; June 2, 1999; July 21, 1999; and August 16 and 24, 1999. *See* JX-3, pp. 58-67.

on his heel which was reportedly caused by his work boots. *Id.* at 7-9, 34-36. Claimant informed Dr. Gidman he had a history of heart disease and diabetes, for which he took medication. Claimant's main complaint at this first visit was significant left foot swelling; Dr. Gidman provided him an elastic sock and returned him to work. *Id.* at 9-10.

Dr. Gidman next treated Claimant on April 20, 1998. He did not have any ulcers on his left foot and the swelling was the same; he continued on regular work duty. Dr. Gidman testified a bone scan confirmed a minimal displacement at Claimant's second metatarsal. (JX-3, pp. 11-12).

On June 17, 1998, Claimant presented to Dr. Gidman with continued swelling of his left foot and poor circulation in both feet; he did not have any ulcers on his feet or complaints of numbness. Dr. Gidman testified the swelling could be a result of Claimant's crush injury or diabetes. Claimant continued with his normal activities. (JX-3, pp. 13-14). Claimant presented to Dr. Gidman again on September 17, 1998, with complaints of left foot pain and decreased sensation on the top of his left foot. The amount of swelling had increased, although Claimant's skin looked normal. Claimant informed Dr. Gidman his job required lots of walking and standing. X-rays taken at this visit revealed dramatic degenerative changes in the area of the metatarsal fractures; Dr. Gidman testified these changes and the accompanying arthritis were a direct result of the trauma Claimant sustained to his left foot. However, he also stated diabetes increases the risk of an incurable infection which could result in the amputation of Claimant's foot. Dr. Gidman prescribed Claimant pain medication and released him to regular duty. (JX-3, pp. 15-17).

Claimant followed-up with Dr. Gidman on February 22, 1999, with increased left leg and foot swelling secondary to a recent job. Claimant's left foot was in the same condition at his next appointment on June 2, 1999. The swelling was worse when his foot was not elevated; Dr. Gidman testified both the injury and diabetes were contributing to Claimant's foot problems. (JX-3, pp. 18-20). Claimant returned to Dr. Sonnier on May 17, 1999, for a skin condition and informed the doctor he was no longer taking his diabetic medications. (JX-17, pp. 16-17). In June, 1999, Claimant had elevated levels of blood sugar, cholesterol and triglycerides. Dr. Sonnier testified these elevated levels were the result of Claimant's going off his diabetes medication. The doctor clarified that failing to take diabetes medication leaves the diabetes uncontrolled; this could lead to complications such as stroke, heart attack, kidney failure, blindness, gangrene, limb amputation, and chronic ulcers. *Id.* at 19-24.

On July 21, 1999, Claimant presented to Dr. Gidman with an ulcer on his left foot and numbness over the entire left foot; he informed Dr. Gidman he was diabetic and took Glucotrol to control his diabetes. Dr. Gidman testified it is notoriously difficult to heal foot disease in diabetics and they often develop peripheral vascular disease. In Claimant's case, the crush injury to his left foot caused significant permanent swelling; Dr. Gidman noted Claimant's numbness was probably diabetic neuropathy compounded by the crush injury which impaired some of the vascularity to the foot. He again opined both the crush injury and the diabetes were playing significant roles in Claimant's foot condition. *Id.* at 21-23, 37, 60. Dr. Gidman testified he found Claimant to be straight-forward; he continued working despite the persistent swelling of his left foot and did not have similar symptoms in his right foot. Moreover, he noted Claimant did not have swelling, pain or numbness in his foot before the 1998 accident. Dr. Gidman testified it was not unusual for Claimant's ulcers to appear one year after the crush; things often happen slowly with diabetics but the foot injury sped things up and had it been worse, the ulcers would have appeared even sooner. *Id.* at 24-26.

Dr. Gidman last examined Claimant on August 16, 1999, at which time the ulcer was larger; Dr. Gidman referred him to Dr. Hebert, an orthopedic surgeon who specialized in foot conditions. Dr. Gidman testified ulcers rarely heal and Claimant's condition was much more significant than if he were not diabetic. He stated working offshore in hot sweaty work boots and standing most of the day may have contributed to the onset of Claimant's ulcers. If they resolve, Claimant may be able to return to work in special fitted orthotics and boots, but he would need to check his feet daily. Dr. Gidman opined heavy duty Longshore work was not a good idea for Claimant. Any job he performs should be foot friendly and involve no pressure on the skin, repetitive foot motions or excessive walking or standing. (JX-3, pp. 27-34). Dr. Gidman clarified Claimant had constant complaints of sensation to pain and swelling in his left foot. *Id.* at 37.

In a letter dated October 11, 1999, Dr. Gidman stated he last saw Claimant August 24, 1999, at which time he had a diabetic ulcer on his left great toe. He opined the ulcer was the result of poor vascularity secondary to chronic diabetes and trauma from wearing work boots. (JX-3, p. 58).

(2) Deposition and Medical Records of Christopher K. Hebert, M.D.

Dr. Hebert testified by deposition on November 14, 2003, and February 13, 2004; he was accepted by the parties as an expert in the field of orthopedic surgery. He first examined Claimant on August 4, 1999, on referral from Dr. Gidman and approximately one and one-half years post-accident.[5] Claimant provided his history of diabetes and described his work accident as a large metal object falling on his left foot; he did not provide any history of trauma to his right foot. Claimant initially presented with an ulcer on his left great toe; there was no documented numbness of his foot. (JX-2, pp. 5-8). At Claimant's August 25, 1999 appointment, Dr. Hebert noted neuropathy in his left foot which was not symptomatic before the 1998 accident. Dr. Hebert testified obesity, diabetes and chronic heavy alcohol use increase incidences of peripheral neuropathy; he described 2-3 beers per day as moderate, not heavy. Dr. Hebert also testified alcohol consumption does not directly affect the occurrence of ulcers. Dr. Hebert stated that as of March 1, 2000, he felt the crush injury was a triggering cause of Claimant's neuropathy. *Id.* at 9-12. At that time, Claimant's left foot chronic ulceration required surgery; Claimant healed without infections which Dr. Hebert considered optimistic. He released Claimant to work without restrictions. *Id.* at 13.

Dr. Hebert examined Claimant on July 26, 2000, at which time he noted Claimant's left ulcer healed completely. However, on November 13, 2000, Claimant presented with an ulcer on his right foot, which Dr. Hebert did not relate to the work accident. Claimant followed up on February 14, 2001; he had greater lack of sensation in his feet and a recurrence of an ulcer on his left foot, which was asymptomatic since July, 2000. Dr. Hebert related the ulcer to the 1998 accident by way of nerve damage secondary to the crush injury. (JX-2, pp. 14-19, 117-18, 126). Dr. Hebert specified the deformity of an extremity plus neuropathy is a setup for ulceration, which can lead to infection and amputation. He testified it was not possible to separate the diabetes or accident from Claimant's ulcers. Dr. Hebert stated people with neuropathy develop ulcers, a risk increased by the presence of bony structure deformities; if serious enough, the deformity could play an equal

[5] Dr. Hebert treated Claimant thirty-nine times in a four year period. He examined Claimant on August 4, 16 and 25, 1999; September 1 and 22, 1999; December 8, 1999; March 1 and 15, 2000; April 5 and 19, 2000; May 10 and 31, 2000; June 26, 2000; July 26, 2000; February 14, 2001; March 2, 7 and 21, 2001; April 11, 2001; May 18, 2001; June 6, 20 and 27, 2001; July 25, 2001; September 5, 2001; October 24, 2001; December 3, 2001; January 2, 2002; May 2, 2002; January 28, 2003; February 12, 2003; March 3 and 31, 2003; April 14 and 21, 2003; May 7 and 19, 2003; June 16, 2003 and July 28, 2003. *See* JX-2, pp. 75-134.

role to neuropathy. However, Dr. Hebert opined the neuropathy was a greater cause than the bone fractures in Claimant's case. *Id.* at 19-21. Claimant's left ulcer completely healed as of June 20, 2001; however, on September 5, 2001, Dr. Hebert noted the existence of chronic bilateral big toe ulcers. (JX-2, pp. 102-08). He testified Claimant's left foot flip-flopped between symptomatic and asymptomatic, but was nonetheless related to the 1998 accident. *Id.* at 24.

Dr. Hebert treated Claimant on January 2, 2002, noting his right foot ulcer was nearly closed, and his left foot ulcer was shallow and not infected. On May 6, 2002, Dr. Hebert assigned Claimant a permanent partial disability rating of 10% (whole body) based on the neuropathy acquired from the work accident. (JX-2, pp. 93-95). On January 28, 2003, Claimant presented with a serious ulcer which developed into gangrene of the third left toe. Dr. Hebert stated gangrene can erupt in a matter of a few days; Claimant's infection had lasted three weeks during which time he tried to take care of it himself. Dr. Hebert amputated the toe on January 30, 2003. (JX-2, pp. 26-28, 59). On April 14, 2003, Claimant presented to Dr. Hebert with an ulcer on his second left toe, which he attributed to his new orthotics and shoes. Dr. Hebert testified the rocker soles of Claimant's shoes helped distribute his weight evenly across his feet; however, on April 21, 2003, he noted Claimant developed foot problems while working despite the special shoes. Claimant had continued ulcerations on his left great and second toes through his July 28, 2003 visit with Dr. Hebert. *Id.* at 29-31, 75-85.

Dr. Hebert testified there was no indication Claimant was making his condition worse by not taking care of his feet; Claimant was attentive at visits, knowledgeable and understanding of the process and has added to the care of his feet. *Id.* at 32. He testified Claimant's 2003 surgery did not keep him from working; however, for the good of his feet he needed to be off manual labor and in a more sedentary position. He clarified that he did not know exactly what Claimant was capable of performing. Dr. Hebert opined if Claimant continued to work manual heavy Longshore work, he could develop a foot condition and infection which would threaten his entire limb. (JX-2, pp. 36-38).

On December 8, 2003, Dr. Hebert examined Claimant's chronic ulcers on his left foot and recommended correcting the bony deformities and straightening out his foot to help heal the ulcers. Dr. Hebert testified neuropathy, as caused by Claimant's injury and diabetes, can cause lesser-toe clawing which places pressure on the tips of the toes. This extra pressure leads to ulcers and straightening the toes through surgical procedures distributes weight evenly across the toes and reduces the occurrence of ulcers. Dr. Hebert testified the metatarsal fractures Claimant

suffered in his 1998 accident may have played a role in the development of the claw-like deformity, but it was more likely a result of the neuropathy. (JX-19, pp. 5-7, 10, 17-18). Dr. Hebert performed the surgery on December 18, 2003; he inserted pins in Claimant's toe joints with no complications. At Claimant's follow-up appointments on December 22, 2003 and January 5, 2004, Dr. Hebert noted Claimant healed nicely. However, Dr. Hebert testified he had to reiterate to Claimant the importance of not placing any weight on his forefoot; he prescribed an open-toe boot and crutches to help with this. On January 12, 2004, Claimant's redness had resolved and x-rays showed signs of healing; however, he was having difficulty standing up from a seated position and Dr. Hebert testified he noticed Claimant was placing weight on his left forefoot. Claimant returned on January 19 with a minor abrasion to his left second toe; Dr. Hebert clipped the pin the next day. On January 28, Dr. Hebert noted Claimant's ulcer healed, his pin site was clean and dry, and he was complying with the non-weight bearing instructions. Dr. Hebert testified the December 2003 surgery was important to prevent the reoccurrence and healing of ulcers on Claimant's left foot. (JX-19, pp. 8-17).

Dr. Hebert testified he was not aware Claimant had voluntarily stopped taking his diabetes medication against the advice of his doctors. While high blood sugar will not cause ulcers, Dr. Hebert clarified that uncontrolled diabetes can prevent the healing of ulcers once present and lead to a greater risk of infection. He further testified that long-standing hyper-glycemia can result in a great risk for the development of neuropathy, which played an equal if not greater role than Claimant's bone deformities in the creation of his ulcers. (JX-19, pp. 20-23). Dr. Hebert testified juvenile diabetes would have also increased the risk for neuropathy being present in Claimant's foot from the beginning; however, he specified that diabetic neuropathy generally occurs bilaterally, and Dr. Gidman only noted neuropathy in Claimant's left foot post-accident. His testimony was based on the assumption that Claimant provided Dr. Gidman with an accurate history of his right foot condition. *Id.* at 26-27.

(3) Deposition and Medical Records of Charles H. Louis, M.D.

Dr. Louis testified by deposition on January 9, 2004; he was accepted by the parties as an expert witness in the field of internal medicine. Dr. Louis first examined Claimant on June 21, 1999, one year and four months after his work-

related accident.[6] Claimant presented with left foot pain which had been consistent since his 1998 accident, as well as an ulcer on his left great toe. Dr. Louis prescribed diabetes medication for Claimant, as he had stopped taking his medication in May, 1999. (JX-18, pp. 6-11). On August 17, 1999, Claimant returned with complaints of left foot pain and left great toe ulcer, which had not improved since the last visit. Claimant was taking his medications and his diabetes was under control. The ulcer was still present at Claimant's November 5 follow-up appointment. *Id.* at 12-14, 18-19.

Dr. Louis testified he primarily treated Claimant for his diabetes and cholesterol; he monitored the ulcers as part of this treatment. Claimant suffered from Type II diabetes, which began when he was an adult. Dr. Louis explained an injury to the pancreas can result in complications with diabetes, although it is not common. He testified Type I diabetes begins in childhood and is treated with insulin injections; oral medications, used for treatment of Type II diabetes, are ineffective for the treatment of Type I diabetes. (JX-18, pp. 14, 22-26). Dr. Louis testified diabetes does not cause ulcers, but can prevent the healing of ulcers. He explained ulcers are directly caused by neuropathy and poor circulation. *Id.* at 31.

On January 13, 2000, Claimant's blood sugar levels were critically high, evidence of his non-compliance with his medications. His left foot was bandaged up from a surgery and he had a healed ulcer on his right foot. Dr. Louis testified that going off and on diabetes medication will reduce its effectiveness, but he clarified that Claimant's non-compliance did not cause his ulcers; he could not even say how much, if at all, Claimant prevented the healing of his ulcers by not taking his diabetes medication consistently. When Claimant resumed his diabetes medication the healing of his ulcers also resumed. Dr. Louis opined Claimant complied with his medications overall, and any non-compliance was not a factor in the condition of his ulcers. (JX-18, pp. 27-29, 32, 73, 76, 83-84). On May 1, 2000, Claimant's blood sugar was fairly controlled, his right ulcer had healed and there was no infection in his left ulcer. However, on July 10, 2000 Claimant's blood sugar was critically high and Dr. Louis had to administer an insulin injection; he also prescribed an additional medication. On July 13, Dr. Louis noted Claimant's blood sugar was still high and he was having problems with palpitation.

[6] Dr. Louis saw Claimant on at least 28 separate occasions, including: June 21, 1999; August 17, 1999; November 5, 1999; January 13, 2000; May 1, 2000; June 20, 2000; July 10 and 13, 2000; August 29, 2000; October 30, 2000; December 5, 2000; February 22, 2001; April 23, 2001; June 2001; September 2001; February 2002; March 1, 2002, June 28, 2002; November 26, 2002; January 28, 2003; February 21 and 27, 2003; April 10, 2003; May 22, 2003; July 3, 2003; August 21, 2003; October 2, 2003; and January 8, 2004. *See* JX-5; JX-18.

Dr. Louis strongly encouraged Claimant to go to the hospital immediately, and when Claimant refused to do so for financial reasons Dr. Louis had him sign a statement he knowingly refused admittance. (JX-18, pp. 34-43; JX-5, pp. 5-6). Records from Our Lady of Lourdes Hospital indicate Claimant was admitted the next day, on July 14, 2000, for cardiac arrhythmia. He was discharged on July 18, 2000, when he felt better. (JX-9, pp. 4, 13).

On December 5, 2000, Claimant followed up with Dr. Louis; he was taking his two diabetes medications and his blood sugar was under control, but he had a chronic ulcer on his right big toe. (JX-18, pp. 46-47). Claimant returned in February, April, June, September, and December 2001; Dr. Louis noted the presence of bilateral great toe ulcers at each visit, although the right ulcer appeared to heal as of September, 2001. (JX-5, pp. 10-14). Claimant continued to suffer from his left great toe ulcer, right great toe ulcer and right great toe cellulitis throughout 2002. (*See id.* at 15-19). On January 28, 2003, Claimant presented to Dr. Louis with a necrotic left third toe and cardiac arrhythmia; he was directly admitted to the hospital. Dr. Louis testified the gangrene on Claimant's toe probably occurred over the period of a week or two, but not overnight. Such condition can develop from foot abuse by wearing closed-toe shoes, getting feet wet and not treating infections. (JX-18, pp. 48-50).

Dr. Louis testified a foot injury can affect one's gait, which probably happened in Claimant's case. Although he did not treat Claimant until 16 months post-accident, Dr. Louis stated Claimant's metatarsal fractures must have altered his gait; indeed, Dr. Louis testified he saw Claimant compensate his gait because of foot pain in June, 1999. Dr. Louis also stated that just wearing a cast can affect ulcers, but he did not know if Claimant actually wore a cast following his injury. (JX-18, pp. 53-56). Dr. Louis testified Claimant's work accident was related to his ulcers, even though the ulcers took 18 months to appear and despite the fact Claimant's diabetes complicated the healing of the ulcers. He testified there was at least some relation between the accident and the ulcers, although he could not say to what degree they were related. *Id.* at 57-59. Dr. Louis also stated excessive alcohol use lead to high blood pressure and poor circulation; he considered a 6-pack of beer per day to be more than usual. (JX-18, p. 82).

(4) Medical Records of Thomas Montgomery, M.D.

Claimant treated with Dr. Montgomery on April 16, 2001, for a non-healing ulcer on his right great toe. Dr. Montgomery noted a left foot infection had healed

over. He reported the wound was probably secondary to repetitive foot trauma; there was no sign of infection or cellulitis in the right toe, and x-rays show no signs of osteomylitis. (JX-6, pp. 9-10). In a letter to Employer's attorney dated November 7, 2003, Dr. Montgomery stated that although he only treated Claimant once for his right toe ulcer, he believed Claimant's left toe condition was more related to his chronic diabetes than his work injury, in part because Claimant suffered neuropathy diffusely throughout both lower extremities. He specified that Claimant's metatarsal fractures and initial ulcers were related to his work accident, but after the ulcers healed over his chronic diabetes was more responsible for the continuing problems and recurring ulcers. Dr. Montgomery based this statement on his review of Claimant's medical records. (JX-20). On March 3, 2004, after reviewing the depositions of Dr. Gidman and Dr. Hebert, he wrote to Employer's attorney a second time, opining Claimant's Type I diabetes could have caused his neuropathy and diabetic ulcers. Dr. Montgomery stated displaced metatarsal fractures are not likely to affect a person's overall foot alignment, or increase pressure on certain areas of the foot. He further stated the ulcers would have occurred sooner if they were indeed caused by the accident. Dr. Montgomery opined Claimant's work injury probably had a minimal role in his left foot condition. (JX-21).

(5) Deposition and Medical Records of Bernard A. Vierra, D.P.M., Carolyn Smith, M.D., Jeff P. Budden, M.D. and Lafayette General Medical Center

Dr. Vierra was accepted by the parties as an expert witness in the field of podiatry. He first treated Claimant on May 6, 2003, for ulcers on his left great and second toes. Claimant provided medical history of diabetes, hypertension, and the amputation of his left third toe. Dr. Vierra found Claimant to have normal blood pressure and slightly elevated blood sugar. (JX-1, pp. 6-9). A physical examination revealed weak tibial pulse in both feet, ankle swelling and varicose veins in Claimant's left foot, ulcers on Claimant's left great and second toes with possible infection and a loss of sensation. Dr. Vierra found Claimant had osteomylitis in his left foot, and multiple bony prominences and spurring on the right foot. He testified he was surprised that the right foot was not the "problem" foot because its condition appeared to be caused from significant trauma. *Id.* at 10-17.

Dr. Vierra testified 50% of his patients are diabetics and he is familiar with the relationship between diabetes and ulcers. He testified ulcers are primarily

caused by neuropathy, which is a nerve problem resulting from loss of circulation; some people are able to control neuropathy with their blood sugar, but it is a degenerative condition that gets worse with time. Dr. Vierra referred Claimant to Dr. Budden for a vascular exam, which indicated normal arteral blood flow in both of his legs. (JX-1, pp. 20-21, 23-24; JX-8, p. 9). Claimant returned to Dr. Vierra on May 8, 2003, who noted the ulcers on both of his toes had improved. Dr. Vierra nonetheless recommended amputating the left second toe, but Claimant chose to keep it. He last saw Claimant on July 7, 2003. (JX-1, pp. 24-28).

Dr. Vierra testified he had no information regarding Claimant's February 1998 work accident, thus could not formulate an opinion as to the relationship between the accident and Claimant's left foot condition. He deferred to Claimant's other doctors for such opinions. He did not remove Claimant from work because he was already off work; he opined Claimant would not do well in a long-term standing position. (JX-1, pp. 31-33). Dr. Vierra testified Claimant's condition is complicated and progressive; it will not heal up and get better, but rather Claimant is on a downhill slide and needs to be protected. Claimant's ulcers are not temporary and will continue to be problematic because of the damage to his bones further complicated by his neuropathy and diabetes. Dr. Vierra opined the 1998 crush injury probably resulted in nerve damage to Claimant's left foot, which could have caused or exacerbated any existing neuropathy. He explained many people have neuropathy and they are okay, but if a person has bony deformities in addition to neuropathy it does not present an optimistic picture. (JX-1, pp. 33-38). He clarified Claimant suffered from neuropathy in both feet, which is common. *Id.* at 39.

Dr. Vierra testified Claimant needs to wear custom-built shoes for diabetics once his ulcers heal. If he wears a typical work boot and stands on his feet all day, his ulcers will get worse. (JX-1, pp. 46-49).

Dr. Smith examined Claimant per Dr. Holden's referral, on May 15, 2003. Upon physical examination, she noted a non-healing ulcer to the left foot, with intermittent pain, numbness and swelling to the left foot. She also reported Claimant's gait was antalgic and non-reciprocal. She related the gait abnormalities as secondary to his work related left foot trauma. Dr. Smith recommended Claimant wear an open-toe fracture boot until his ulcer healed. (JX-7, pp. 1-3).

IV. DISCUSSION

A. Contention of the Parties

Claimant contends his current foot condition is causally related to 1998 work incident and subsequent crush injury. Specifically, he argues the crush injury caused, at least in part, neuropathy in his left foot which led to the development of infectious ulcerations on his left foot. In addition, the crush injury resulted in fractured metatarsal bones in his left foot and altered his gait, which also attributed to his chronic ulcers. At a minimum, Claimant argues his crush injury combined with his diabetes to cause the neuropathy and ulcerations to appear earlier than they would have absent the injury, thus they are compensable under the Act. Claimant is requesting indemnity compensation from January 28, 2003, when Claimant stopped working secondary to his foot injury and left third toe amputation.

While Employer does not refute the accident resulted in Claimant's crush injury and initial ulcerations on his left foot, it contends those injuries healed as of 2000 and the chronic recurrence of the ulcers thereafter were caused by his diabetes, not his injury. Furthermore, Employer contends Claimant contributed to his ulcers by drinking 4-5 beers per night, voluntarily refusing to take his diabetes medication and not checking his feet on a regular basis. Employer argues the evidence indicates Claimant may have had neuropathy prior to the 1998 accident as a result of his childhood Type I diabetes. Employer contends the totality of the evidence severs any connection between the accident and his current ulcers, thus it has sufficiently rebutted the Section 20(a) presumption and established the 1998 accident did not cause Claimant's chronic foot ulcers. Employer submits Claimant is not entitled to indemnity compensation beyond what was already paid in 2000 and 2001.

B. Causation

(1) Claimant's *prima facie* case

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the claimant in establishing that a harm constitutes a compensable injury under the Act:

> In any proceeding for the enforcement of a claim for compensation under this chapter it shall be presumed, in the absence of substantial evidence to the contrary - -
> (a) That the claim comes within the provisions of this chapter.

33 U.S.C. § 920(a).

To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that: (1) the claimant sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. *Port Cooper/T. Smith Stevedoring Co., Inc., v. Hunter*, 227 F.3d 285, 287 (5th Cir. 2000); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129 (1984). Once this *prima facie* case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. *Hunter*, 227 F.3d at 287. "[T]he mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." *U.S. Industries/Federal Sheet Metal Inc., v. Director, OWCP*, 455 U.S. 608, 615 (1982). *See also Bludworth Shipyard Inc., v. Lira*, 700 F.2d 1046, 1049 (5th Cir. 1983)(stating a claimant must allege an injury arising out of and in the course and scope of employment); *Devine v. Atlantic Container Lines*, 25 BRBS 15, 19 (1990)(finding the mere existence of an injury is insufficient to shift the burden of proof to the employer and a *prima facie* case must be established before a claimant can take advantage of the presumption). Once both elements of the *prima facie* case are established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. *Hunter*, 227 F.3d at 287-88.

In the present case, the injuries for which Claimant is seeking compensation, and for which Employer denies the same, are those sustained after 2000 when his initial ulcerations healed. In July, 1999, Dr. Gidman noted Claimant's foot problems were the result of his diabetes compounded by his crush injury; he further testified that ulcers rarely heal. Despite Claimant's diabetes, the crush injury accelerated the neuropathy in his foot and Claimant's condition is worse than if the injury never happened. As of March, 2000, Dr. Hebert was of the opinion Claimant's crush injury was a triggering cause of his left foot neuropathy and subsequent ulcers. Although Claimant's left foot ulcers healed in July, 2000, Dr. Hebert related their recurrence in 2001 back to the 1998 crush injury which affected the nerves in his left foot. Dr. Hebert testified bony deformities plus

neuropathy are a setup for ulcerations, and it was impossible to separate out the diabetes or the injury from Claimant's foot condition. He added that although Claimant's left foot flip-flopped between being symptomatic and asymptomatic in 2000 and 2001, the condition was nonetheless related to the 1998 crush injury. Dr. Hebert further testified Claimant suffered a claw-like deformity in his left foot which may have been caused by his crush injury, but was more likely the result of his neuropathy. He stated the December, 2003 surgery to correct the deformity was important to relieve the pressure on Claimant's forefoot and prevent future ulcerations on his left toes. Additionally, Dr. Louis testified Claimant's foot ulcers were related to his 1998 crush injury, despite the fact they took 18 months to form. Although Dr. Vierra did not examine Claimant until five years post-injury, based on information provided at his deposition he opined the 1998 crush injury probably resulted in nerve damage to Claimant's left foot which could have cause or exacerbated any pre-existing neuropathy.

Claimant clearly suffered from a physical harm or pain, in that he had swelling, neuropathy and chronic ulcers in his left foot which led to the amputation of his third left toe. Dr. Gidman related his foot condition to the 1998 injury, and Dr. Hebert specifically testified the continued recurrence of the ulcers could be related back, at least in part, to Claimant's 1998 injury. Dr. Louis and Dr. Vierra also opined the two are related. As such, I find Claimant's work accident could have caused his chronic foot condition, and the Section 20(a) presumption is invoked.

(2) Rebuttal of the Presumption

"Once the presumption in Section 20(a) is invoked, the burden shifts to the employer to rebut it through facts - not mere speculation - that the harm was not work-related." *Conoco, Inc. v. Director, OWCP*, 194 F.3d 684, 687-88 (5th Cir. 1999). Thus, once the presumption applies, the relevant inquiry is whether the employer has succeeded in establishing the lack of a causal nexus. *Gooden v. Director, OWCP*, 135 F.3d 1066, 1068 (5th Cir. 1998); *Bridier v. Alabama Dry Dock & Shipbuilding Corp.*, 29 BRBS 84, 89-90 (1995)(failing to rebut presumption through medical evidence that claimant suffered an prior, unquantifiable hearing loss); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144-45 (1990)(finding testimony of a discredited doctor insufficient to rebut the presumption); *Dower v. General Dynamics Corp.*, 14 BRBS 324, 326-28 (1981)(finding a physician's opinion based of a misreading of a medical table insufficient to rebut the presumption). The Fifth Circuit further elaborated:

> To rebut this presumption of causation, the employer was required to present substantial evidence that the injury was not caused by the employment. When an employer offers sufficient evidence to rebut the presumption--the kind of evidence a reasonable mind might accept as adequate to support a conclusion--only then is the presumption overcome; once the presumption is rebutted it no longer affects the outcome of the case.

Noble Drilling v. Drake, 795 F.2d 478, 481 (5th Cir. 1986)(emphasis in original). See also, *Orto Contractors, Inc. v. Charpender,* 332 F.3d 283, 290 (5th Cir. 2003), *cert. denied* 124 S.Ct. 825 (Dec. 1, 2003)(stating the requirement is less demanding than the preponderance of the evidence standard); *Conoco, Inc*., 194 F.3d at 690 (stating the hurdle is far lower than a "ruling out" standard); *Stevens v. Todd Pacific Shipyards Corp.*, 14 BRBS 626, 628 (1982), aff'd mem., 722 F.2d 747 (9th Cir. 1983)(stating the employer need only introduce medical testimony or other evidence controverting the existence of a causal relationship and need not necessarily prove another agency of causation to rebut the presumption of Section 20(a) of the Act); *Holmes v. Universal Maritime Serv. Corp.*, 29 BRBS 18, 20 (1995)(stating the "unequivocal testimony of a physician that no relationship exists between the injury and claimant's employment is sufficient to rebut the presumption.").

In the present case, Employer submits there is comprehensive evidence which serves to rebut the connection of Claimant's 1998 work accident and his chronic ulcerations. Specifically, Dr. Montgomery stated after the initial ulcers healed over, their recurrence was the result of Claimant's diabetes more than the work injury. Additionally, Dr. Montgomery stated Claimant's Type I diabetes could have caused his neuropathy and ulcers. He also opined if Claimant's ulcers were indeed related to his work injury, they would have occurred much sooner than 18 months post-accident. Dr. Vierra testified the neuropathy could be the result of Claimant's diabetes and regular alcohol consumption. Employer relies on the medical testimony of Dr. Louis, Dr. Hebert and Dr. Gidman, indicating Claimant voluntarily went off of his diabetes medication; Dr. Louis testified uncontrolled diabetes can lead to the recurrence of ulcers. Claimant also did not inform his doctors about his childhood Type I diabetes, which could have caused his neuropathy. In July, 2000, Claimant refused hospital admittance despite Dr. Louis' insistence that his blood sugar levels were life-threatening; Employer contends this evidence indicates Claimant was not a good patient and exacerbated his condition. Employer also highlights the fact Dr. Gidman noted Claimant had

normal gait 10 days post injury, and Dr. Montgomery stated displaced fractures did not lead to ulcers, noting Claimant did not miss any work in 2002 despite his alleged foot ulcers.

Although the evidence is relatively weak, it nonetheless is substantial enough to rebut the Section 20(a) presumption and Claimant's *prima facie* case. Although Dr. Montgomery's statements of causation are not absolute, combined with Claimant's history of diabetes and the course of his current foot condition I find the evidence as a whole calls into question the connection between the 1998 crush injury and Claimant's continued, chronic foot ulcers. Thus, the presumption no longer controls the issue of causation in this matter, and the evidence must be weighed as a whole.

(3) Causation on the Basis of the Record as a Whole

If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. *Del Vecchio v. Bowers*, 296 U.S. 280, 286-87 (1935); *Port Cooper/T Smith Stevedoring Co. v. Hunter*, 227 F.3d 285, 288 (5th Cir. 2000); *Holmes v. Universal Maritime Serv. Corp*., 29 BRBS 18, 20 (1995). In such cases, I must weigh all of the evidence relevant to the causation issue. If the record evidence is evenly balanced, then the employer must prevail. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994).

In the present case, the medical testimony of Dr. Louis established that diabetes does not directly cause ulcerations of the feet; rather, diabetes can cause neuropathy, or loss of feeling, which leads to the ulceration. Dr. Louis and Dr. Vierra both explained neuropathy and the subsequent ulcerations are progressive conditions which can only be slowed down, not cured. Claimant, a diabetic, did not have problems with his left foot prior to the 1998 work accident which resulted in metatarsal fractures, swelling and loss of sensation. Dr. Gidman noted the fractures healed with some minor displacement and significant degenerative changes developed in the area of Claimant's fractures in September 1998. Dr. Gidman testified Claimant's injury impaired the vascularity in his left foot, compounding his diabetes and leading to the neuropathy. Although the ulcers did not appear until 16 months after the accident, Dr. Gidman explained such conditions progress slowly in diabetics; had the foot injury been worse the ulcers would have appeared even sooner. Dr. Hebert's testimony was consistent in that he opined Claimant's crush injury combined with his diabetes to cause the neuropathy in his left foot. Even if Claimant suffered some amount of neuropathy prior to the

1998 accident, as Employer contends, Dr. Gidman and Dr. Hebert opined the accident exacerbated the condition and triggered Claimant's symptomatic neuropathy. Employer's argument is further rebutted by Claimant's credible testimony he had no problems with swelling or numbness in his left foot prior to 1998.

Additionally, in 1998, Dr. Gidman only noted deformities in Claimant's left foot; the right foot was asymptomatic. Dr. Hebert testified diabetic neuropathy usually occurs bilaterally, and Claimant's asymptomatic right foot indicated to him that the left foot condition was related to the work accident. In April, 2001, Dr. Montgomery noted no infection or cellulitis of the right toe and x-rays indicated there was no osteomylitis in the right foot; this was consistent with Dr. Gidman's reports that Claimant's right foot was not symptomatic following his work accident. Dr. Hebert also opined Claimant's deformities, the metatarsal fractures, also played a role in the formation of his ulcers although not as much as the neuropathy itself. He testified the bony deformities and neuropathy combined to cause the clawing of Claimant's left foot, which in turn placed undue pressure on the toes and exacerbated the ulcers. Dr. Louis opined the fractures could have resulted in Claimant altering his gait and placing more pressure on one part of his foot than another, resulting in ulcerations; he even opined the altered gait could have played a role in Claimant's right foot ulcerations. Although Dr. Louis did not treat Claimant until more than one year after the accident, he testified he witnessed Claimant compensate his gait secondary to left foot pain in June, 1999. Additionally, Dr. Smith recorded Claimant's altered gait secondary to his work accident, in May, 2003. Dr. Montgomery stated, however, that displaced metatarsal fractures are not likely to alter Claimant's gait or increase the occurrence of ulcers on either of his feet.[7] Nonetheless, I find the opinions of Dr. Hebert and Dr. Louis, as corroborated by Dr. Smith, outweigh that of Dr. Montgomery, and the evidence establishes that Claimant's crush injury resulted in his metatarsal fractures, neuropathy, antalgic gait and subsequent ulcers.

Employer contends Claimant's work injury ceased playing a role in his foot condition after the initial ulcers healed in 2000; rather, it argues his diabetes was

[7] While Employer relied on Dr. Montgomery's statements to rebut the Section 20(a) presumption, I note he only examined Claimant on one occasion, for a right foot ulcer in 2001. Moreover, his statements are contradictory in that first he states the accident caused Claimant's fractures and initial ulcers; then he stated if the ulcers were caused by the accident they would have occurred sooner than 16 months. Dr. Montgomery never testified but only submitted a report and two letters to Employer's attorney, based on his review of Claimant's medical records and the testimony in this case. As such, I place little weight on his opinions and do not rely on them where they are inconsistent with the testimony as a whole.

the cause of his chronic ulcers. I note Dr. Gidman and Dr. Louis both testified neuropathy and ulcerations are progressive conditions which are virtually irreversible. Dr. Gidman testified it was not out of the ordinary for Claimant's initial ulcer to appear 16 months post-accident, as these conditions progress slowly in diabetics. Moreover, Dr. Louis testified diabetes played only an indirect role in causing ulcers, which primarily result from neuropathy. Pursuant to Dr. Gidman's testimony, it is reasonable to conclude the neuropathy played a continued role in Claimant's chronic ulcerations, as the neuropathy itself is an ongoing condition. Thus, as the accident caused Claimant's neuropathy, I find it also played a role in his chronic ulcerations.

Employer submits Claimant made his own condition worse by refusing treatment for his diabetes and heart condition on multiple occasions, and consuming more than a usual amount of alcohol on a daily basis. Indeed, Claimant informed Dr. Gidman in 1998 that he drank 4-5 beers per night; he testified at the hearing he drank 2-3 beer per night. I also find Claimant did not inform his doctors he previously had Type I diabetes which had resolved prior to his 1998 accident. Claimant went off of his diabetic medication in 1999 and initially refused to be hospitalized in July, 2000, for critically high blood sugar. Employer also alleges Claimant did not regularly check his feet which led to the development of gangrene in his left foot in January. 2003. Dr. Louis, Claimant's diabetes physician, and Dr. Sonnier both testified non-compliance with diabetic medication would result in uncontrolled diabetes and further prevent the healing of Claimant's ulcers. Dr. Hebert testified his opinions as to the causation of Claimant's ulcerations might change if Claimant was non-compliant with his medications; I note Dr. Hebert did not have first-hand knowledge of this presumed non-compliance. Additionally, Dr. Hebert testified he witnessed Claimant placing weight on his left fore foot in 2003, despite recommendations he not do so in order to aid the healing of his surgeries and ulcerations. The medical evidence also established gangrene can erupt rather quickly, although Claimant's infection was present for about 2-3 weeks in January, 2003, despite his attempts to treat it himself.

As Dr. Louis specializes in internal medicine and was Claimant's treating physician for diabetes, I place more weight on his opinions regarding the diabetes. He testified Claimant was compliant with his diabetes medication in general and once he resumed his medications the healing of his ulcers also resumed. Additionally, Dr. Louis stated any non-compliance on Claimant's behalf did not have an affect on the overall condition of his left foot. Although Claimant initially refused Dr. Louis' recommendation of hospitalization July 13, 2000, for monetary

reasons, he checked into the hospital the following day. Dr. Hebert testified chronic alcohol use does not directly affect the occurrence of ulcers, but may play a role in loss of sensation. Moreover, Dr. Hebert testified Claimant was a knowledgeable, attentive and understanding patient who added to the care of his feet. Dr. Gidman testified he considered Claimant straightforward. Thus, I find Claimant actively participated in the treatment of his diabetes and care of his feet. He attempted to treat his feet himself, and continued to work despite his disability because he needed the money. Although he may not have been the perfect patient, I do not find that Claimant's actions serve to establish a lack of causation between his 1998 accident and chronic left foot ulcers.

In conclusion, the totality of the evidence weighs in Claimant's favor and I find his 1998 workplace accident caused, or at least exacerbated and accelerated, his left foot neuropathy. Although his diabetes played a role in the chronic ulcers, they would not have appeared absent the neuropathy. Claimant's doctors found him to be a good patient overall despite some instances of non-compliance with medication and post-surgical instructions. While Claimant was a regular beer drinker, the evidence does not indicate his alcohol consumption may have caused his ulcers. Rather, the evidence remains that Claimant's left foot was asymptomatic prior to his February 7, 1998 accident but following the accident it was swollen, painful and numb. Claimant did not experience these symptoms in his right foot until at least 2003, when Dr. Vierra examined him. As such, I find it reasonable to conclude Claimant's current left foot condition, including his January, 2003 toe amputation and December, 2003 surgery, is a result of his compensable workplace accident and he is entitled to compensation under the Act.

D. Nature and Extent of Injury

Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10) (2003). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Seidel v. General Dynamics Corp.*, 22 BRBS 403, 407 (1989); *Stevens v. Lockheed Shipbuilding Co.*, 22 BRBS 155, 157 (1989). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of

maximum medical improvement (MMI). The determination of when MMI is reached, so that a claimant's disability may be said to be permanent, is primarily a question of fact based on medical evidence. *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989).

In the present case, Dr. Gidman and Dr. Louis both testified neuropathy is an irreversible progressive condition which can only be slowed down; Claimant's condition has indeed only worsened over the past 5 years. Dr. Hebert assigned Claimant a permanent partial disability rating of 10% (whole body) on May 6, 2002; however, there was no explanation for this rating and Claimant's condition significantly deteriorated after that date, leading to the amputation of his left third toe in January, 2003. As of January 27, 2003, Claimant was no longer able to perform his former job and indeed has not held any job. Following his toe amputation on January 30, 2003, and despite the lack of medical testimony regarding this topic, I note Claimant's medical condition has remained essentially unchanged. The parties do not address the issue of MMI in the depositional testimony, at the hearing, or in their post-hearing briefs. As such, I find Claimant has reached MMI as of January 27, 2003 and is permanently disabled as of that date.

Case law has established that in order to establish a *prima facie* case of total disability under the Act, a claimant must establish that he can no longer perform his former Longshore job due to his job-related injury. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981); *P&M Crane Co. v. Hayes*, 930 F.2d 424, 429-30 (5th Cir. 1991). He need not establish that he cannot return to *any* employment, only that he cannot return to his former employment. *Elliot v. C&P Telephone Co.*, 16 BRBS 89 (1984). If a claimant meets this burden, he is presumed to be totally disabled. *Walker v. Sun Shipbuilding & Dry Dock Co.*, 19 BRBS 171 (1986). In the present case, Claimant has been off of work since January 27, 2003. All of his physicians opined he should not return to work offshore because it would be too strenuous on his feet. They testified he should return to a foot-friendly job which would not require a lot of standing or walking. Dr. Gidman suggested the job should not involve pressure to the foot skin, repetitive foot motions or excessive walking or standing. Dr. Hebert testified Claimant should be off of a heavy manual job and placed in a more sedentary position. Dr. Vierra also testified if Claimant continues to wear regular work boots and stand on his feet all day, his ulcers will only get worse. Thus, Claimant has sufficiently established a *prima facie* case of total disability as his doctors opine he is not capable of returning to his regular work offshore.

Once the *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. *Turner*, 661 F.2d at 1038; *P&M Crane*, 930 F.2d at 430. Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. *SGS Control Serv.*, 86 F.3d at 444; *Palombo v. Director, OWCP*, 937 F.2d 70, 73 (D.C. Cir. 1991); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). An employer may establish suitable alternative employment retroactively to the day when the claimant was able to return to work. *New Port News Shipbuilding & Dry Dock Co.*, 841 F.2d 540. 542-43 (4th Cir. 1988); *Bryant v. Carolina Shipping Co., Inc.*, 25 BRBS 294, 296 (1992). In the present case, Employer submitted no evidence of suitable alternative employment. Although Claimant's doctors do not indicate he is incapable of working any job, he has not worked at all since January 27, 2003. No evidence of Claimant's vocational abilities or available suitable alternative employment opportunities was presented by Employer. As such, I find Claimant continues to be permanently totally disabled.

E. Interest

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. *Avallone v. Todd Shipyards Corp.*, 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. *Watkins v. Newport News Shipbuilding & Dry Dock Co.*, *aff'd in pertinent part and rev'd on other grounds, sub nom*. *Newport News v. Director, OWCP*, 594 F.2d 986 (4th Cir. 1979). The Board concluded inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982)." This order incorporates by reference this statute and provides for its specific administrative application by the District Director. *See Grant v. Portland Stevedoring Company, et al.*, 17 BRBS 20 (1985). The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

F. Attorney Fees

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision to submit an application for attorney's fees. A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

1. Employer shall pay to Claimant permanent total disability compensation pursuant to Sections 908(a) of the Act for the period from January 28, 2003 to the present and continuing based on a stipulated average weekly wage of $1,173.17 and a corresponding compensation rate of $782.11.

2. Employer shall pay Claimant for all past and future reasonable medical care and treatment arising out of his work-related injuries pursuant to Section 7(a) of the Act.

3. Employer shall pay Claimant interest on accrued unpaid compensation benefits. The applicable rate of interest shall be calculated at a rate equal to the 52-week U.S. Treasury Bill Yield immediately prior to the date of judgment in accordance with 28 U.S.C. §1961.

4. Claimant's counsel shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges, serving a copy thereof on Claimant and opposing counsel who shall have twenty (20) days to file any objection thereto.

A

CLEMENT J. KENNINGTON
ADMINISTRATIVE LAW JUDGE